DOCUMENT RESUME

ED 440 312 CG 029 829

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TITLE Helping Children, Adolescents, and Families Cope during/after a Disaster.
PUB DATE 2000-03-29
NOTE 35p.; Paper presented at the Annual Convention of the National Association of School Psychologists (32nd, New Orleans, LA, March 28-April 1, 2000).
PUB TYPE Guides - Non-Classroom (055) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; Children; Coping; Counseling Techniques; *Crisis Intervention; Elementary Secondary Education; *Emergency Programs; Family Relationship; *Mental Health; *Natural Disasters; *School Psychologists; Violence
IDENTIFIERS Red Cross

ABSTRACT

This paper and accompanying workshop address the changing and expanding role of school psychologists resulting from disasters and increasing violence in schools and communities. The objectives of this workshop were: to encourage school psychologists to expand their roles to include crisis intervention as an essential part of their service deliveries; to help school psychologists develop more expertise in helping children, adolescents, and families cope during, and in the aftermath of, a disaster; to share information about disasters in general and the experiences of a Red Cross mental health disaster volunteer; and to provide participants with an opportunity to introspect about their feelings in dealing with several types of disasters. The paper includes step-by-step guidelines and suggestions for school counselors on topics including, "The Four Phases of Disaster," "Disaster Mental Health (DMH)," "Principles To Follow for Providing Services to Children and Families," "Attachment and Separation Theory," "Ways Parents Can Support Their Children during/after a Disaster," "Three Ways To Help Children Cope with Disaster," "School Psychologists as Consultants to Educators," and "Group Crisis Intervention." (Contains 25 references.) (GCP)

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ED 440 312

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS' CONVENTION

New Orleans, Louisiana
March 29, 2000

Helping Children, Adolescents, and Families Cope During/After a Disaster

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INTRODUCTION

Presently, school psychologists provide multiple services: Assessment, Prevention, Intervention, Consultation, Education, Health Care Provision, Research, and Planning. Because of federal and state laws, many school districts have prioritized assessment. Consequently school psychologists have been spending a significant amount of their service delivery time evaluating children and adolescents referred for motivational, cognitive, emotional, behavioral, and/or medical reasons.

However, within the last decade, the role of the school psychologist has been changing and expanding as a result of the impact of disasters and increasing violence in our schools and communities. Some school districts have already experienced disasters: disasters that were weather-related, accident-related, illness-related, or bizarre and unusual (such as school shootings).

Since disasters are inevitable, school psychologists need to be prepared as much as possible to help children, adolescents, and families cope during and in the aftermath of a disaster. NASP has taken leadership in this area. In its alliance with the National Organization for Victim Assistance (NOVA), a National Association of School Psychologists/National Emergency Assistance Team (NASP/NEAT) has been formed. It developed a school community crisis response plan that has been implemented in various communities. Survivor testimony has demonstrated the

success of our leading NASP/NEAT crisis respondents who have intervened using NOVA's group crisis intervention model. The NASP/NEAT accomplishment is one example of the Celebrating Success (2000 NASP Convention Theme).

At the New Orleans workshop, participants will be provided information about disasters in general, and about tornadoes, specifically. In May of 1999, during the Oklahoma tornado disaster, the American Red Cross activated this nationally certified school psychologist, a trained mental health disaster volunteer, to service. This professional offered crisis intervention to adults, parents, children, and adolescents as well as to some families. Crisis methodology and lessons learned from the Oklahoma experience will be shared at the 2000 New Orleans NASP Convention. Since the Oklahoma experience, this certified school psychologist was also called to service to assist at the EgyptAir 990 disaster; and at fires that killed six firefighters in Worcester, Massachusetts; six family members in Lynn, Massachusetts; and four persons (one also died soon after the fire)in Newton, Massachusetts. Some lessons learned at the EgyptAir and fire disasters will also be included at the NASP Convention.

In addition, an introspective exercise relating to disasters will be presented to all NASP participants attending the workshop.

The objectives for this workshop are:

(1) to encourage school psychologists to expand their roles to include crisis intervention as an essential part of their service deliveries:

(2) to help school psychologists develop more expertise in helping children, adolescents, and families cope during and in the aftermath of a disaster;

(3) to share information about disasters in general and about this certified school psychologist's experiences as a Red Cross mental health disaster volunteer; and

(4) to provide participants with an opportunity to introspect about their feelings in dealing with several types of disasters.

Since this paper and workshop were prepared for participants with limited experience in the topic of disaster, several complete quotations are purposely included to give the school psychologists the full measure of each of the expert's suggestions in their own words.

DEFINITION OF DISASTER

The Federal Emergency Management Agency (FEMA) defines a disaster as follows:

> A **major disaster** is defined as any natural catastrophe, or regardless of cause, any fire, flood, or explosion that causes damage of sufficient severity and magnitude to warrant assistance supplementing state, local, and disaster relief organization efforts to alleviate damage, loss, hardship, or suffering. Events associated with disaster

> are capable of causing traumatic stress when they cause or threaten death, serious injury, or the physical integrity of individuals. (FEMA, Pub. 229 (4), November 1995, p. 1).

Quarantelli (1985, pp.41-52) combines seven elements to answer the question, "What is a disaster?"

1. **Physical agents** (the fires, floods, tornadoes, etc.).
2. **Physical impact** (the visually observable destruction done by the physical agents).
3. **Assessment of physical impacts** (the damage has to exceed certain thresholds).
4. **Social disruption** (due to physical damage).
5. **Social constructions of reality** (perceptions of the seriousness of the impact)
6. **Political definitions** (official disaster declarations).
7. **Demands for action** (which exceed normal response capabilities).

DISASTER TYPOLOGIES

According to Farberow and Gordon (1986), "Disasters vary in size, scope, extent of damage, loss of life, injury, and degree of disruption to the family and the community. They may be natural or manmade events, extend over a few moments or many months" (p. 3). Young (1994) categorizes disasters into a three-fold classification according to **cause**: natural, industrial, or human (such as school shootings); and according to **elements**: (earth, air, fire, water, and people). "Catastrophes, in general, progress through eight time stages: pre-disaster

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conditions, warning, threat, impact, inventory, rescue, remedy, and recovery" (Farberow and Gordon, 1986, p. 3). Although disasters and/or their timing usually occur unexpectedly, some can be anticipated. Planning for a disaster can prevent it from becoming overwhelming and causing undue loss.

THE FOUR PHASES OF DISASTER

There are four physical aspects (phases) of disaster that correspond to survivor emotional reactions (Weaver, 1999, p. 1). They are quoted as follows:

1. **Heroic Phase:** This phase occurs prior to or at the time of the disaster. Individuals in a community work together to save each other and their property. Everyone is concerned with survival.
2. **Honeymoon Phase:** This phase takes place within two weeks to two months after the disaster. Being promised help from government and communal agencies, the survivors feel optimistic about rebuilding their lives.
3. **Disillusionment Phase:** This phase lasts from about two months to one to two years after the disaster. Due to frustrations with bureaucracy's recovery delays, failures, and paperwork, the survivors turn to themselves to begin to rebuild their lives. Their frustration with organizations is identified as the "Second Disaster."
4. **Reconstruction Phase:** This phase may last for several years after the disaster. Individuals and the community work

together to rebuild and reestablish normal functioning.

A CHART OF SURVIVOR EMOTIONAL REACTIONS TO THE FOUR PHASES

Cited from the American Red Cross Disaster Relief brochure (p. 3), the following are the four phases along with the emotional reactions of survivors for each phase:

HEROIC PHASE	HONEYMOON PHASE	DISILLUSIONMENT PHASE	RECONSTRUCTION PHASE
Shock	Attend to basic needs in chaotic environment	Reality of impact on lives and community	Light at the end of the tunnel
Fear	Concerns about safety, food for today, place to sleep	Realization of losses and work to be done	Begin to put the disaster behind
Confusion	Unrealistic expectations about recovery	Procedures to get assistance	Renewed feeling of empowerment
Adrenalin rush	Sharing of resources/ willingness to help others	Community politics begin to emerge	Post-traumatic stress disorder
Heroic acts		Grieving	Return to pre-disaster activities
People coming together		Psychosomatic complaints	
		Abuse issues	

DISASTER MENTAL HEALTH

The American Red Cross (1987) reports that disaster mental health (DMH) services function at three levels (population, environment, and individual) and can be classified into five types (education, problem solving, advocacy, referral, and intervention). Weaver (1999) describes disaster mental health as follows:

> Disaster mental health (DMH) is designed to help the victims (and the relief workers who rush to their aid) learn to cope effectively with the extreme stresses they will face in the aftermath of a disaster. The primary skills used for DMH intervention are advocacy, mediation, education, defusing, and debriefing (p. 1).

Weaver (1999, p. 1) further delineates the goal of DMH:

> The goal of DMH is to prevent the development of long-term, negative psychological consequences of a disaster such as the development of PTSD. Victims and relief workers will be changed by their encounters with disasters, but the majority of them will not be damaged by those experiences.

The following quotes are Weaver's (1995, pp. 67-87) list and descriptions of seven helping processes used by DMH workers:

1. **Emotional First Aid** - This consists of 11 suggestions:

   a. Remain calm - Be an appropriate role model.

   b. Introduce yourself and your agency/services role.

   c. Get needed demographic information immediately.

   d. Use active listening skills and allow plenty of time for ventilation.

   e. Give process details that help lessen fear of the unknown.

   f. Be truthful about what you have to offer and be careful not to overstate it.

   g. Verify attentiveness. You may need to repeat things several times for survivors in shock.

   h. Usually, it is best not to stop any tears.

   i. Sometimes, giving a hug may help.

   j. Shun 'Superman/Wonderwoman' urges and involve others.

   k. Learn to recognize and remember your own limitations.

2. **DMH Crisis Intervention -** There are three objectives.
   a. To relieve feelings of survivor (or helper) anxiety, depression, and guilt.
   b. To prevent further disorganization or decompensation.
   c. To screen for those persons with more serious problems and/or issues that may require additional services (and possibly need ongoing mental health treatment).

   With DMH interventions, a three-part formula is employed: Get People Talking; Get People Busy Doing Something Constructive; and Begin Problem Solving.
3. **The Miraculous Healing Powers of Sleep -** Sleep, or lack of it, can be the DMH worker's best friend or worst enemy. Survivors and DMH workers need to sleep in order to deal with the disaster and its aftermath.
4. **Defusing** - This is the process of talking it out - allowing victims and workers the opportunity to ventilate about their disaster-related memories, stresses, losses, and methods of coping.
5. **Debriefing** - This is a formal meeting, generally held 24 to 72 hours after an unusually stressful incident, strictly for the purpose of dealing with the residuals of the event.
6. **Critical Incident Stress Debriefing (CISD)** - The CISD model, also known as the Mitchell model, involves an individual group interview between the emergency respondents who witnessed a critical incident and a facilitator (or

sometimes several facilitators). There are four types of debriefing: On-Scene (or Near-Scene); Initial Defusing; Formal CISD; and Follow-Up CISD. The paradigm consists of seven phases: Introduction; Fact; Thought Reaction; Emotional Reaction; Reframing; Teaching; and Re-Entry.

7. **Screening** - The DMH worker needs to screen survivors and workers in crisis to determine those who need short-term interventions and those who need to be referred to other helping agencies.

THE IMPORTANCE OF THE FAMILY IN THE HEALING PROCESS

The emotional symptoms of a child survivor can only be understood in the context of his/her family as the child affects the family members and the family members affect the child. When a disaster threatens to or does separate children from their families, a strong and traumatic sense of separation anxiety occurs. **After violence or a disaster occurs, the family is the first-line resource for helping.** Consequently, in this paper, strategies to assist parents to help their children are included in order to guide school psychologists in their family interventions. Early intervention is critical.

SOME KEY CONCEPTS OF DISASTER MENTAL HEALTH

Disaster mental health services differ from mental health programs in non-disaster times. The U.S. Department of Health and Human Services (1994, p. 1) identifies fourteen differences that are cited here:

1. **No one who sees a disaster is untouched by it.** This not only includes those survivors of disasters but also those who witnessed it or heard about or saw it. It also involves mental health workers who help.
2. **There are two types of disaster trauma.** One is **individual trauma** that manifests itself in the stress and grief reactions which individual survivors experience; the other is **collective trauma** which can sever the social ties of survivors with each other and with the locale.
3. **Most people pull together and function during and after a disaster, but their effectiveness is diminished.** In the early 'heroic' and 'honeymoon' phases of the disaster, survivors are upbeat. However, as the realization of the loss becomes more real, the grief reactions intensify and impair functioning.
4. **Disaster stress and grief reactions are a normal response to an abnormal situation.** Survivors need to be informed of the normalcy of their reactions. However, in some cases, the grief responses can be pathological (warranting therapy or counseling) if the grief is an intensification, a prolongation, or an inhibition of normal grief.
5. **Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.** The problems of living are basic to existence such as locating missing loved ones; finding temporary housing, clothing,

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and food; getting medical care; replacement of eyeglasses or medication; and applying for financial assistance.

6. **Disaster relief procedures have been called, 'The Second Disaster.'** This is described as the process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement, and acquiring help from private or voluntary agencies is often fraught with rules, red tape, hassles, delays, and disappointment. Families are forced to deal with organizations that seem or are impersonal, inefficient, and inept.

7. **Most people do not see themselves as needing mental health services following disaster and will not seek out such services.** Many people equate 'mental health' services with being 'crazy.' With the pragmatic pressures of putting the concrete aspects of their lives back together, the survivors do not see psychological intervention as a top priority.

8. **Survivors may reject disaster assistance of all types.** People may be too busy with cleaning up and other concrete demands to seek out services and programs that might help them. The bottom-line impact of losses is often not evident for many months or, occasionally, for years

9. **Disaster mental health assistance is often more 'practical' than 'psychological' in nature.** At first, mental health

services is practical and concrete and responds to the basic needs of the survivors. Mental health workers perform any practical function that is needed to meet the basic needs of survivors.

10. **Disaster mental health services must be uniquely tailored to the communities they serve.** The demographics and characteristics of the affected community; the type of community (urban, suburban, or rural); the ethnic and cultural variability; and the integration of the mental health services with the existing community agencies must be considered.

11. **Mental health staff need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.** The traditional 'office-based' approach to therapy is of little use in disaster work. Workers should avoid the term 'mental health' and instead identify their services as **'assistance,' 'support,' or 'talking.'** Instead of waiting for survivors to come to the mental health worker, an outreach program should be initiated. Mental health workers need to go to where the survivors are and assist them in any way possible.

12. **Survivors respond to active interest and concern.** When approach with warmth and genuine concern, survivors usually are eager to talk about their experience. Mental health

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workers should approach the survivors and not feel that they are intruding or invading their privacy.

13. **Interventions must be appropriate to the phase of disaster.** There are four phases, and the mental health worker needs to recognize the emotional reactions to each of the phases. In the 'heroic' and 'honeymoon' phases, the survivors may feel optimistic rather than bereaved. In the 'disillusionment' phase, the survivors are cognitively trying to piece the disaster together and to understand what happened. They become frustrated with the bureaucratic delays and failures. In the 'reconstruction' phase, the individual and the community work together to rebuild. In talking with a survivor, the mental health worker does not have to talk about the crisis but can also communicate about ordinary events.
14. **Support systems are crucial to recovery.** The most important support group for individuals is the family. Workers should attempt to keep the family together (in shelters and temporary housing, for example).

OTHER DMH KEY CONCEPTS

Weaver (1999, p. 3) adds the following key DMH concepts:

1. **People do not disintegrate.**
2. **The disaster climate has a way of generating lots of rumors.**
3. **Disasters bring out the best and worst in people.**
4. **The DMH worker must be sensitive to cultural, ethnic, racial,**

and socioeconomic diversity and respond accordingly.

5. **Helpers are subject to a vast array of physical and emotional responses to crises, including burnout.**
6. **Workers can find strength (and peer supports) in numbers.**

PRINCIPLES TO FOLLOW FOR PROVIDING SERVICES TO CHILDREN AND FAMILIES

The National Institute of Mental Health (NIMH)(1986, p. 4) has promulgated the following principles that have been derived from sound clinical practice and prior experience in disaster intervention. They are quoted here for the benefit of school psychologists at the NASP Convention.

1. **Reactions of children to disasters have both short-term and long-term effects.** They may be short or long term in respect to the duration or to the immediate or delayed occurrence after the disaster, or both.
2. **The children and their families are primarily normal people, but because of the severe stress, their functioning may be disrupted temporarily.** Equilibrium is usually established with or without intervention; however, informed intervention can accelerate recovery and can prevent serious problems later.
3. **The basic unit of treatment, when possible, should be the entire family, not just the individual child.**

4. **The family is the first-line resource for helping the children and should be considered before involving other treatment resources.**
5. **Because most of the subjects are normal, mental illness labels should be avoided.** Descriptive and not professional terms should be used.
6. **Selection of the label or name for the crisis services is left to the individual program.** A neutral way to identify the service is to identify it as **'someone to talk to.'**
7. **The traditional model approach should be avoided.** Workers in disasters should seek out users of their services rather than wait to be sought out. Outreach teams can be activated.

ATTACHMENT AND SEPARATION THEORY

John Bowlby's attachment theory and its opposite, separation theory, are applicable to children's responses to disasters. The National Institute of Mental Health (1986) emphasizes the relationship and importance of the two terms:

> Because attachment behavior is more readily elicited in childhood, the young are especially prone to distress when there is no one available and responsive when needed. Separation or threat of separation from an attachment figure is a particular vulnerability of children (p. 8).

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THREE COMMON CHILDREN'S REACTIONS TO A DISASTER

Waddell & Thomas (1999a&b, p. 119 & 123) identify three common children's emotional reactions which can vary in nature and severity from child and child. They are quoted here:

1. **Loss of Control** - By their very nature, disasters are something over which we have no control-if we did, we would stop them from happening. The feeling of loss of control can be overwhelming.
2. **Loss of Stability** - Disasters also interrupt the natural order of things. Stability is gone and this is very threatening; it can destroy trust and upset equilibrium for extended periods. After all, if this disaster could happen, then most anything else might happen too.
3. **Self-centered Reactions**: Children's immediate reaction to disaster often includes a fear for their own safety. They may be intensely worried about what will happen to them, to an extent that you think is unreasonable. However, young children have difficulty putting the needs of others before their own. Children need repeated reassurance regarding their own safety and the outcome of the disaster as it relates to them.

WAYS PARENTS CAN SUPPORT THEIR CHILDREN DURING/AFTER A DISASTER

Waddell & Thomas (1999a, p. 120) identify ways parents can support their children during a disaster. As these

suggestions are applicable to the school psychologist as a crisis intervenor of an individual child or of parents who need guidance to help their children, they are cited here:

1. **Try to recognize the feeling underlying your child's actions and put it into words.** Saying something like 'I can see you are feeling really sad about this' can help.
2. **Sometimes children may have an overwhelming fear that they are unable to put into words, and you may need to voice for them.** For instance, if a friend loses his mother during a tornado, you might want to say to your child, 'You may be scared that something will happened to me and daddy (or mommy) too.'
3. **Be honest with your child about what has happened and what is happening.**
4. **Don't deny the seriousness of the situation.** Saying to a child, 'Don't cry, everything will be okay' does not reflect how the child feels, and the child knows that, at least in the immediate future, this is not true.
5. **Help your child know what words to use with others.** For instance, if the disaster has resulted in death, the child may feel overwhelmed about what to say to friends at the funeral home. You may need to help by suggesting some simple appropriate words.
6. **Plan a practical concrete activity to help children deal with feelings.**

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7. **Involve children in decisions about what to do to restore their sense of having control in their lives.** Possible activities include:
   a. Collecting money for disaster victims.
   b. Planting a tree as a memorial for a death.
   c. Designing cards and writing notes to someone involved in the disaster.
   d. Drawing pictures and putting up a bulletin board.
   e. Writing poems or stories for a class book about the disaster.
8. **Inform your children's teachers about how they are reacting and find out what is being done in the classroom to deal with the disaster.**
9. **Decide how to handle attending funeral or memorial services.** If the disaster involves deaths, whenever possible parents should take their own children to services. Provide information about the funeral and its structure to prepare children for the experience.

ADDITIONAL WAYS PARENTS CAN SUPPORT THEIR CHILDREN DURING/AFTER A DISASTER

The National Institute of Mental Health (NIMH, p. 4) identifies several ways parents and other caring adults can help children. School psychologists can integrate these when helping the child or family. The suggestions are quoted here:

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1. **Explain the episode of disaster as well as you are able.**
2. **Encourage the children to express their feelings and listen without passing judgment.** Help younger children learn to use words that express their feelings. However, do not force discussion of the traumatic event.
3. **Let children and adolescents know that it is normal to feel upset after something bad happens.**
4. **Allow time for the youngsters to experience and talk about their feelings.** At home, however, a return to routine can be reassuring to the child.
5. **If your children are fearful, reassure them that you love them and will take care of them.** Stay together as a family as much as possible.
6. **If behavior at bedtime is a problem, give the child extra time and reassurance.** Let him or her sleep with a light on or in your room for a limited time if necessary.
7. **Reassure children and adolescents that the traumatic event was not their fault.**
8. **Do not criticize regressive behavior or shame the child with words like 'babyish.'**
9. **Allow children to cry or be sad.** Don't expect them to be brave or tough.

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10. **Encourage children and adolescents to feel in control.** Let them make some decisions about meals, what to wear, etc.

11. **Take care of yourself so you can take care of the children.**

THREE WAYS TO HELP CHILDREN COPE WITH A DISASTER

To help children cope with disasters, Feinberg (1999, p. 135) includes the Federal Emergency Management Agency (FEMA) suggestions which are now cited:

1. Plan for a Disaster

a. Talk to children about the likely disaster in their community.

b. Teach children about the safety precautions for each disaster.

c. Prepare a family disaster plan.

d. Explain how to call for help.

2. Provide Comfort

a. Take a child's fears seriously.

b. Keep the family together.

c. Include children in the clean up process.

d. Allow children to make some decisions regarding the family.

e. Leave time for play.

f. Increase attention: Children may require more attention during this period. Try to meet these additional

demands on your time, i. e., a child wanting to be held more should be held more.

g. Maintain control.

h. Reassure children that you will do your best to protect them in this difficult situation.

i. Be understanding, but firm. Be aware that children may act out of fear or anxieties by having tantrums or provoking fights. Calm, consistent limit setting is called for from parents and teachers.

j. Seek help from local organizations.

3. **Communicate:**

Children will naturally be curious about what happened. Explain the facts about what happened and encourage the child to ask questions. Use these guidelines when talking with children:

a. Use words or phrases that won't confuse children. For instance, use of the word 'sleep' for death can cause a child to fear going to bed.

b. Make sure children understand your answers to their questions.

c. Listen to children's feelings and accept them.

d. Remember that children--just like adults--may react with unusual behavior such as wide emotional shifts.

e. Help children talk with each other about what has happened and how they are feeling.

SCHOOL PSYCHOLOGISTS AS CONSULTANTS TO EDUCATORS

When a disaster affects a whole school or community, the teachers and administrators can play a prominent role in the healing process. By knowing about the following cited NIMH (p. 5) suggestions, school psychologists can guide the educators to help children:

1. If possible, teachers should give themselves a bit of time to come to terms with the event before they attempt to reassure the children.
2. Don't try to rush back to ordinary school routines too soon. Give the children or adolescents time to talk over the traumatic event and express their feelings about it.
3. Respect the preferences of children who do not want to participate in class discussions about the traumatic event. Do not force discussion or repeatedly bring up the catastrophic event; doing so may re-traumatize children.
4. Hold in-school sessions with entire classes, with smaller groups of students, or with individual students.
5. Offer art and play therapy for children in primary school.
6. Be sensitive to cultural differences among the children.

7. Encourage children to develop coping and problem-solving skills and age-appropriate methods for managing anxiety.
8. Hold meetings for parents to discuss the traumatic event, their children's response to it, and how they and you can help. Involve mental health professionals in these meetings if possible.

TREATING TRAUMA

Schmookler (1996, pp. 4-17) summarizes a three-fold guideline for working with survivors who have been catastrophically violated. They are quoted as follows:

1. The survivors suffer:

a. intense emotion and reactivity
b. numbness
c. flashbacks
d. nightmares
e. triggering events
f. other

2. The survivors need to:

a. feel safe.
b. know that you will respect their boundaries.
c. leave if they want to.
d. know that they will not be touched if they do not want to be.
e. feel accepted and not judged.

f. talk and be listened to.

g. be believed.

h. have their feelings paid attention to.

i. to be left alone if desired

3. You Can Help the Survivors:

a. Your **presence** is the most important gift you can give.

b. Besides being compassionate, mental health workers need be detached, to be neutral.

c. Begin simply by introducing yourself.

d. Let the survivor lead.

e. Ask questions. This shows you are actively listening to them.

f. Always work with permission.

g. As long as the survivor is not overwhelmed and is willing, create space for her/him to move into discussing more emotionally difficult material.

h. Let people tell their story.

i. Allow the experience and expression of feeling.

j. Ask the survivor what she/he feels.

k. Reflect what you hear and see.

l. Do not push for catharsis.

m. If the person seems overwhelmed, lead away from emotionally painful material.

n. Enhancing the feeling of safety is another way to reduce feeling overwhelmed and to allow integration of difficult material.

o. Help people recognize and develop their resources.

p. Avoid pushing for recovery too soon.

q. Take care of yourself.

GROUP CRISIS INTERVENTION

At times, disaster mental health workers will offer intervention to groups. In 1996, The National Association of School Psychologists (NASP) formed a National Emergency Assistance Team (NEAT) and began using the National Organization for Victim Assistance (NOVA's) crisis intervention protocol. In order to learn more about this intervention, school psychologists are referred to Poland & McCormick (1999), Canter and Carroll (1999), the November 1998 NASP Communique, and Young (1998) to learn more about this NASP recommended group process. School psychologists should also be aware of the Critical Incident Stress Debriefing model (CISD) also known as the Mitchell debriefing model. Information about this paradigm can be researched in Everly and Mitchell (1999) and Everly (1995).

SOME LESSONS LEARNED FROM MY RED CROSS EXPERIENCES

For nearly two weeks, this mental health disaster volunteer, a member of the American Red Cross Disaster Services Human Resources System, was called to service to

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assist at **the May 1999 Oklahoma tornadoes**. Having attended the all-day NEAT/NOVA group Crisis Intervention workshop in Las Vegas, Nevada, in April, I had the opportunity to implement part of the NOVA group crisis model in Oklahoma and to apply it to individuals. Many lessons were learned from my Oklahoma experience. The following are some of them:

1. Part of the NOVA group crisis model can be implemented successfully with individuals.
2. The survivors accepted the trauma with a biblical interpretation. They praised the Lord and thanked Him for sparing whatever they had left. I am now more conscious of how religion can influence one's perception of trauma.
3. We, as mental health workers, cannot introduce ourselves as such, or as psychologists, social workers, or counselors as these labels are a turn off to some. Instead, I introduced myself as "**involved with the healing process**."
4. We need to avoid the passive word "victim" and instead use the active term "survivor" which implies some control over oneself and the world.
5. Disaster mental health services not only include psychological/social assistance but also practical and

survival services. This was a valuable lesson and reminded me of Maslow's Hierarchy of Needs model.

Although **the November 1999 EgyptAir 990 disaster** occurred in Massachusetts, the command center for helping the relatives of the victims was in Rhode Island. Once again, I learned about the importance of religion and spirituality in the lives of survivors. I also learned **about "the psychology of presence"** at this international and intercultural airline disaster. One's presence or being with someone can and does at times mean more than all of the skills and academic degrees we attain. What is most important to individuals who experienced a traumatic event is that they know that you are there and that you care.

Throughout my Red Cross stay, I was readily available and present with my Red Cross vest. Although some of the Egyptians communicated only in Arabic, and I could only converse in English, some relatives of the deceased approached me and used nonverbal language to express their needs. Those who reached out sought medical attention. In return, I also employed nonverbal language to communicate with and to help them. **I learned that we, as disaster workers, do not always have to be proactive. There are times when we just have to be there, to be present, to be available, and to be ready to help in any way when and as needed, not only with psychological intervention, but especially with the fulfillment of basic human, survival, and practical needs.**

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At the fires, I saw the comforting effect of religious faith. I met clergy of various denominations who comforted the grieving survivors and the relatives of the deceased. They were very effective in helping the individuals cope with the traumatic event. I witnessed the clergy's positive and healing influence, not only at the fire sites, but also at the tornado and aircraft disasters. I am happy I had the opportunity to help others and to lessen the impact of the post-traumatic (critical incident) stress effect.

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